Vermont 1115 Waiver Demonstration
Choices for Care
Quarterly Report July 2006 – September 2006

Summary:

The fourth quarter marks the completion of the first year of implementation of Choices for Care. This quarter continued on with activities begun in the previous quarter: continuation of re-defining program elements to more clearly reflect program and participant needs, ongoing work on the design and implementation of the Flexible Choices (Cash and Counseling) portion of the program, and committee work on the development of payment to spouses and the final work of getting PACE ready to open its doors.

Fourth Quarter Events:

Developing effective communication among all of the providers continues to be a significant priority for the successful operation of the Choices for Care program. The Long Term Care Waiver Teams, operational in each Human Services District, continue to meet monthly under the leadership of the 12 regional Long Term Care Clinical Coordinators. These meetings have become a central repository for information exchange regarding the status of program participants, applicants and program operation changes and challenges. Each region of the state operates a little differently in terms of what the group determines as effective for their communities. The Coordinators continue to work to bring all the partners to the table. In some areas, generally the more rural areas with a limited number of providers, the waiver team consists of all the Choices for Care partners. In other areas it is a challenge to reach the hospital discharge planners and the nursing home admission coordinators. Efforts will continue to recruit these members, although it is recognized that a paradigm shift needs to occur for these institutional based providers to reach outside to the larger community. Some of this has begun with weekly teleconferences between the management staff of Choices for Care with discharge staff at the state's largest hospital, Fletcher Allen Medical Center.

Monthly meetings with the major service providers continue to be beneficial. Progress has been made in creating a comfort level among these partners. As communication has increased, it seems that Choices for Care is becoming part of the system of care services in Vermont. Less and less time is being requested by provider groups in needing to raise programmatic concerns. The evolution that is taking place is that providers are requesting the presence of Choices for Care staff at their meeting

with the intent of resolving a particular topic. This has been a progression from early in the program year when it was determined that staff needed to be present at each monthly meeting of each provider group to answer a range of isolated situations. The benefits of having gone through this process are that some problems were identified as being system-wide matters or areas that affected policy. The Choices for Care and other DAIL staff have worked to resolve those systemic and policy matters. This has resulted in a less critical need to have staff present at all provider meetings regularly. It is anticipated that in the next year, staff will be available on request as providers have concerns that they need to bring to the table. Topics of concern raised during this quarter focused on billing concerns, timeliness of the financial determination of applicants, and follow through by providers on the completion of paper work on change of settings, level of care and terminations.

Monthly meetings continued with Choices for Care staff, the Department for Children and Families/Economic Services Division (eligibility determination unit), OVHA (Medicaid Managed Care entity) and EDS (Medicaid claims processing entity). Improvements have been seen as a result of the previous quarter's activities. Meetings have been cut in half and the goal going forward is to establish written protocols for billing denials. An outstanding challenge continues to be receiving notification of participant status by particular provider groups. Efforts continue with regular written communication and individual meetings with each of the providers.

The delay in financial eligibility determinations, although improved, remains a creeping issue. The 60 day closure effort by the waiver team review has made a positive impact in lessening that gap. Discussion with the Department for Children and Families, the Medicaid eligibility organization, continues and DAIL and DCF continue to explore ways to reduce that time lag.

The Long Term Care Clinical Coordinators (LTCCC) continued to meet monthly with central office staff. During the fourth quarter, a new staff member in the Division was introduced as the clinical consultant. This individual is available to confer with the LTCCC on difficult case. This has been a useful resource to the regional staff.

Flexible Choices, Vermont's Cash and Counseling Program, began enrollment on July 24, 2006. By the end of this quarter, two individuals were receiving services using a Flexible Choices budget. While initial enrollment is very small, DAIL is listening to consumer and advocate feedback about program challenges and is working to address them.

PACE development and implementation continues with weekly meetings between the PACE state staff, Individual Support Unit staff, EDS, other state departments and the PACE provider.

The State and PACE continue to respond to questions from CMS staff. The PACE Center and the State are also heavily involved in preparing for the readiness review which is scheduled for October.

The proposal to pay spouses as caregivers is still under review with implementation scheduled for January-February 2007.

On October 1, 2005 all nursing home residents, community- based and enhanced residential care participants were migrated into the SAMS data base system. A total of 3,447 individuals were automatically enrolled in Choices for Care –

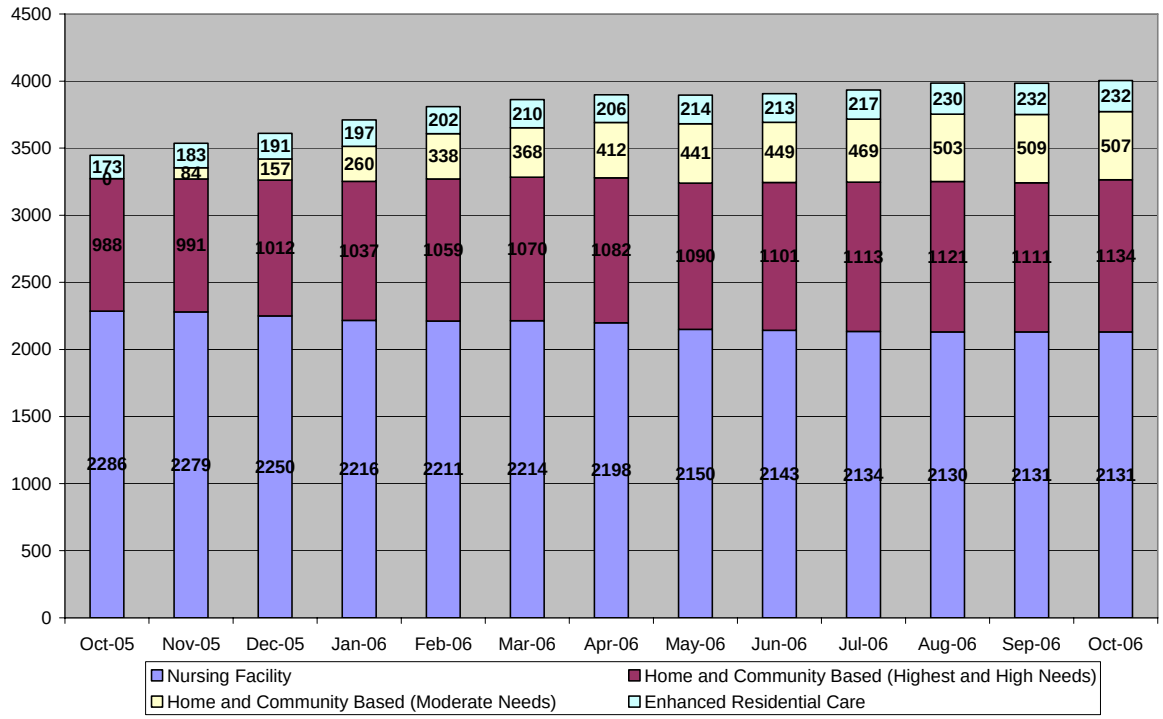
- 2,286 were nursing facility residents;
- 988 were home and community-based residents; and,
- 173 were enhanced residential care residents.

As of October 1, 2006 there were 4,004 individuals enrolled, a net gain of 557 individuals in 12 months, including the moderate needs group –

- 2,131 nursing facility residents;
- 1,134 home and community-based individuals;
- 232 enhanced residential care residents; and,
- 507 moderate needs group

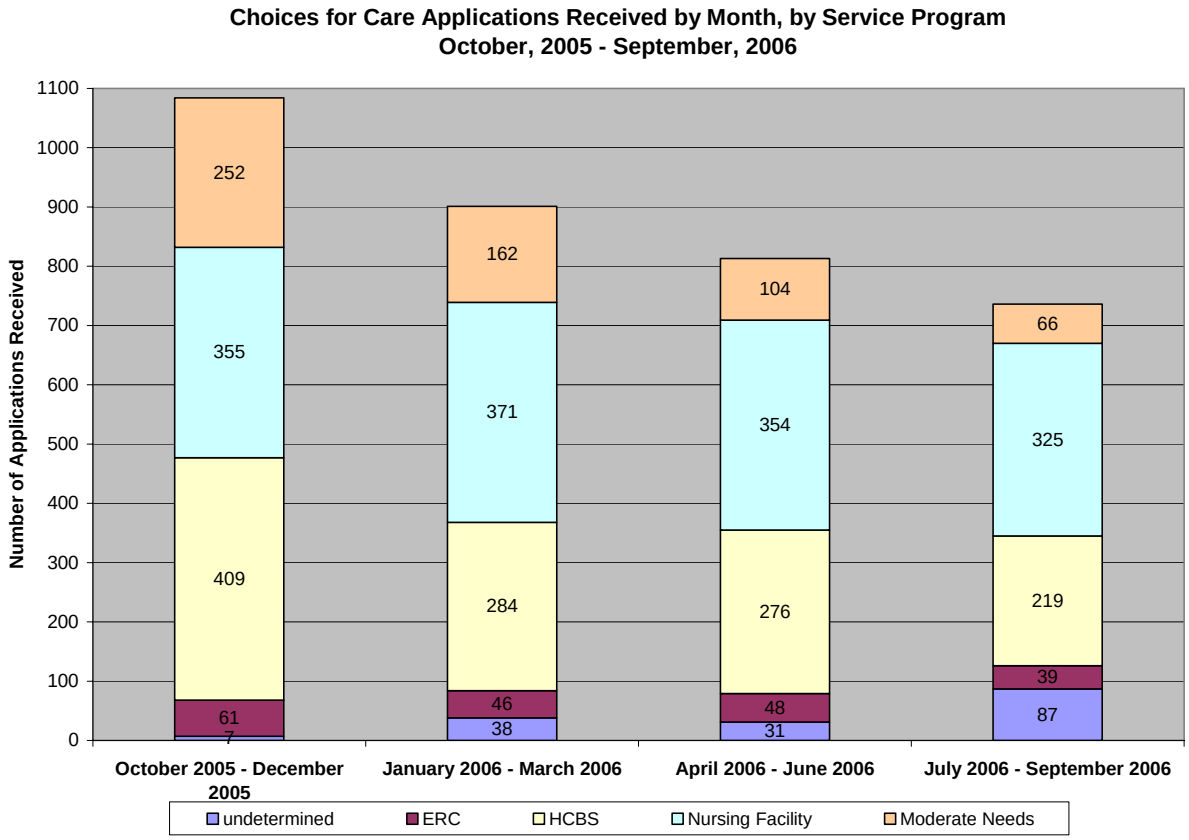
The following chart shows the number of participants enrolled in each setting over time. The number of people served in nursing homes has decreased, while the numbers of people served in the Home and Community Based and Enhanced Residential Care settings have increased.

Choices for Care: Total Number of Enrolled Participants
October 1, 2005 - October 1, 2006



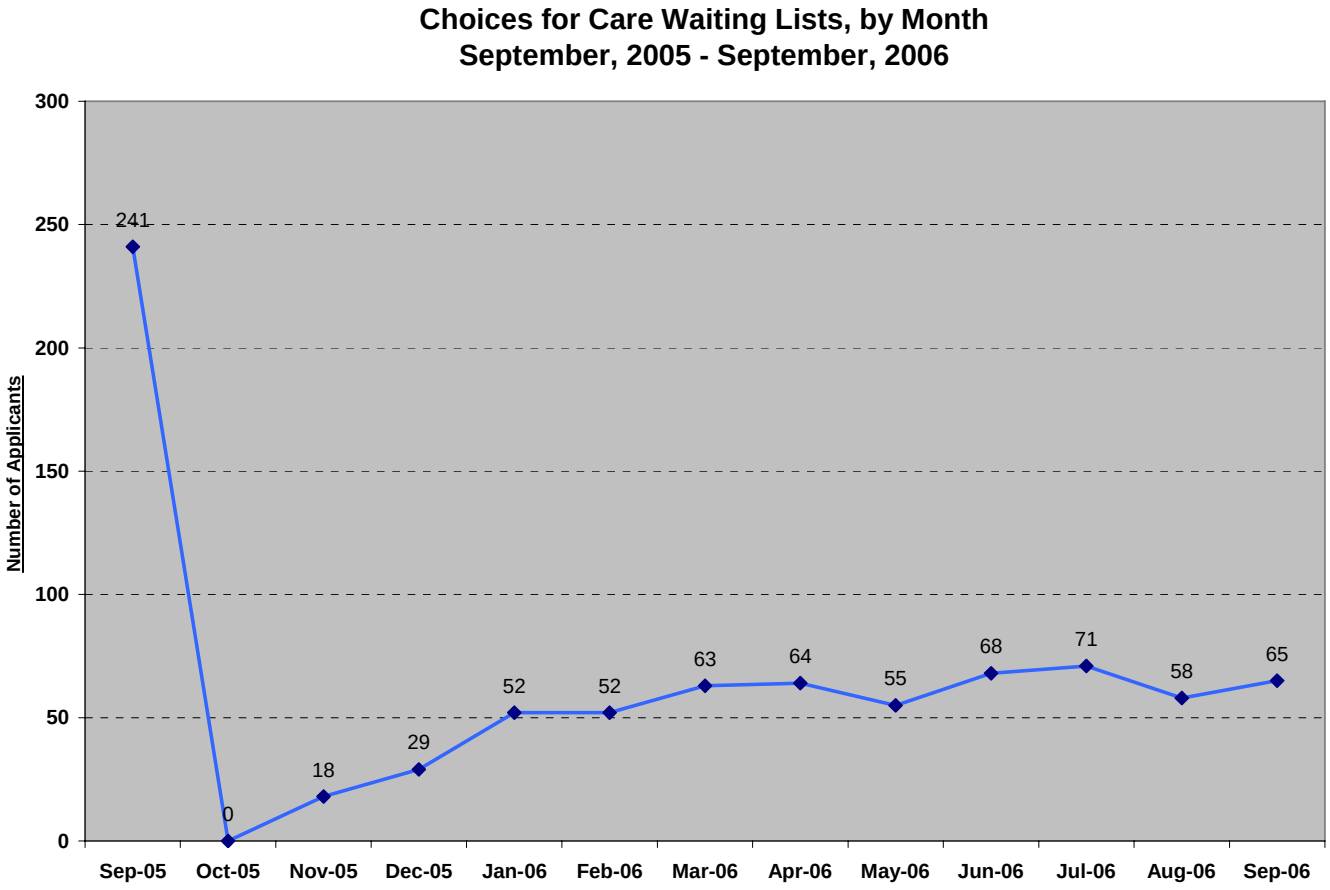
In the Home and Community-based system for the Highest/High Needs Groups and Enhanced Residential Care, the number of people served increased by 205, double what would have been possible under the former 1915 (c) waiver. The Moderate Needs Group increased from 0 to 509 individuals, as DAIL brought preventative services to a group of individuals not previously served in the waiver program.

DAIL/DDAS continues to receive a substantial number of applications each month, averaging 267 applications per month for the last six months. The number of applicants for the Nursing Facility setting continues to represent the largest group, followed by applicants for the Highest and High Needs Groups in the Home and Community-based setting. The graph on the following page shows the decline in applications since the initial backlog of individuals on the original waiting list prior to implementation of Choices for Care.



One of the goals of Choices for Care is to process individual applications in a timely manner. This following graph shows the months in which currently pending applications were received. While most applications are fully processed within two months, a small number have been pending for many months. Long application delays are commonly associated with various delays in Medicaid eligibility:

1. Long-term care Medicaid applications are not submitted.
2. Long-term care Medicaid applications are delayed or incomplete.
3. Some applicants under the age of 60 (those not already eligible for SSI) must be found eligible through the Disability Determination process, which routinely requires several months.
4. Some applications require complicated asset searches and/or legal review by the Department for Children and Families.
5. Staff vacancies or absences at the Department for Children and Families.



Applicants who meet the High Needs Group eligibility criteria, but for whom there may be insufficient funding, are placed on a waiting list. The number of people on this waiting list has averaged 65 for the last six months.

Prior to the implementation of Choices for Care, access to Home and Community-based Services and Enhanced Residential Care was limited by available funds, and many applicants were routinely placed on waiting lists. The total number of people on waiting lists fell substantially when Choices for Care was implemented in October, 2005, when those applicants who meet Highest Needs Group eligibility criteria became entitled to services.

Based on the availability of funds, eleven people from the High Needs Group waiting list were enrolled in Choices for Care during July, 2006. Some other people from the waiting list have been admitted under special circumstances or because their needs increased, such that they met the Highest Needs Group eligibility criteria.

The average approved cost of HCBS Highest/High Needs Group Plans of Care was $3,513. The average costs in four counties (Grand Isle, Chittenden, Addison, and Franklin) were well above the average costs in other counties. The available evidence suggests that factors other than individual functional assistance needs contribute to the regional variation in costs. These factors include:

1. Greater use of Home Health Agency personal care services, at a higher reimbursement rate, as opposed to consumer or surrogate-directed care at a lower reimbursement rate;
2. Requests for hours of personal care services that are above average; and,
3. Greater use of adult day services.

Nursing facility paid Medicaid days continue to run 1% below the planned amount in this quarter. Expenditures for two months are also 1% below the planned amount.[1] In the first year of operation, Choices for Care saved approximately 1.6 million dollars (state and federal), while serving more people in home and community-based services.

Paid claims	October '05	December '05	March '06	September '06
Home based, Including moderate	$2,261,219	$3,344,840	$2,804,888	$2,636,044
ERC	$248,600	$292,522	$281,557	$329,422
Nursing Home	$8,619,253	$8,637,174	$12,997,034	$9,338,754

As part of the Real Choices System Change QA/QI Grant, the Quality Management Committee continued to meet in August and September. Work on desired outcomes of services and indicators were completed. Work on data sources and data points was begun. The Quality Management Unit, working in collaboration with other DDAS staff, continued implementation of the *Choices for Care Interim Quality Plan and On-site Review Protocol.*

The Quality Management Unit completed reviews for three Choices for Care service providers and began reviews for another two providers within this reporting period. The Quality Management Unit administered the Participant Experience Survey E/D to 38 consumers during this quarter, making the total surveys administered to date 55.

[1] 5/3/06Act160-06.xlwjim's monthly

Challenges for the Quality Management Unit staff are due in part to the rigorous quality management activities are new to many Choices for Care service providers, some entities continue to be resistant to change in implementing the *Choices for Care Interim Quality Plan*. Presentations, open dialogue, and ongoing support have been a key to overcoming this challenge.

Now that the Quality Management Unit has conducted several service provider reviews, the types of training, technical assistance, and support these entities need are becoming clearer. Discussions within DDAS Leadership Team have begun in order to address those needs.

Conclusion:

The first year of Choices for Care has been exciting and daunting, all in one. State staff, including DAIL and its other state agency partners in DCF and OVHA, as well as EDS staff, CFC providers from nursing facilities, to adult day providers, to enhanced residential care homes to payroll services, have all been challenged by the first in the nation systemic changes that have happened in the debut year of Choices for Care. While every effort was made to provide consistent, well thought out directions for consumers and providers, there were a few challenges to overcome. We provided regular updates to CMS as well as to our legislative oversight committee.

The first year of Choices for Care has been a success. Initial results show that we saved $1.6 million and served more people. All-in-all Vermont is proud to have undertaken such a change and we truly believe that it has enabled the beginnings of a true paradigm shift towards thinking about community-based care not just as an alternative to nursing home care, but as <u>the</u> preferred and initial option for service and support to Vermont's older citizens and those with physical disabilities.